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INSURANCE CONSENT/RELEASE FORM

Dr. Sue B. Davis, clinical psychologist, is hereby granted my permission to release to and receive from

(Full Name of Insurance Co.)

(Full Name of Secondary Ins. Co.)

Such information as may be necessary regarding the treatment of

(Print Full Name of Patient)

The purpose for such disclosure is: To file insurance claims for reimbursement, to request more sessions for ongoing treatment, and any other routine insurance information/request relative to patient's treatment and billing information.

Specific information to be released may include:

Diagnosis, Dates of Service, Treatment Plans, Summary Requests, Telephone Consults to authorize additional sessions and the like.

This consent may be revoked at anytime. However, I am aware that once I have waived my privilege of confidentiality by releasing information to anyone other than my attorney, I may not be able to restrict access to that information at a later point in a legal proceeding.

(Patient signature)

(Date)

(Patient signature)

(Witness)

CONFIDENTIALITY NOTICE: This message is intended only for the use of individual or entity to which it is addressed and may contain information that is privileged, confidential or exempt from disclosure under applicable law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that you are strictly prohibited from reading, disseminating, distributing, or copying this communication. If you have received this communication in error, please notify us immediately at the number indicated above and return the original message to us at the above address via the U.S. Postal Service. Thank you.